Since 1995, IDF has taken the lead in conducting national surveys of patients with primary immunodeficiencies. Our survey data has been used effectively to advocate with government for legislative and regulatory remedies for our patients, has been cited and used by medical professionals to outline patient treatment and diagnosis experiences, as well as by industry and government to understand the demand for and efficacy of immunoglobulin replacement therapy. IDF survey data has been indispensable in furthering the understanding of these diseases by better defining the health status, treatment patterns and psychosocial experiences of our patients.

One of the most quoted IDF survey findings is from the IDF 2002 National Patient Survey — 9.2 years is the average time from the onset of symptoms to diagnosis for patients with primary immunodeficiency. This discovery has stunned many— “How could diagnosis take this long?” and outraged others—“Something must be done!” Nonetheless, over the years, the 9.2 years average has become universally acknowledged and accepted.

However, new data from the IDF 2007 National Patient Survey has provided us with some interesting results. It would appear as though the average time to diagnosis for patients with primary immunodeficiency disease has increased from 9.2 years to 12.4 years. Since the second survey excluded patients who were included in the 2002 survey, the true average for all patients would actually be between 9.2 and 12.4 years.

The first reaction many have to this news— “How can it be getting worse with all the awareness, education and new medical advances?” may not be appropriate. In addition, the average age of the patients in the 2007 survey was almost 39 years, compared to 34 years in the 2002 survey. These results do not necessarily indicate that it is taking patients longer to become diagnosed. It could mean that recognition of these diseases has actually improved and, that some adults with “mystery” illnesses have finally received a definitive diagnosis.

The 2007 Patient Survey also saw an increase in the proportion of patients reporting Common Variable Immune Deficiency Disease (CVID) as their diagnosis. These findings would be consistent with longer times to diagnosis, as those with CVID consistently report longer times from symptom onset to diagnosis than those who report other specific primary immunodeficiency disease diagnoses.
Diagnosis—How Long Does It Take?

These longer times to diagnose are often periods of repeated infections for patients. Crippling infections unfortunately can lead to permanent impairments or loss of function. Survey respondents were asked if they experienced any permanent impairments or loss of function in such areas as the lungs, digestive system, in their vision, hearing or even if they had mobility or neurological issues before they were diagnosed.

As the chart below indicates, those who were diagnosed in fewer than 9 years had the best chance of avoiding life-long impairments and enjoying a higher quality of life. Although immunoglobulin therapy can reduce the frequency and severity of infections in patients with antibody deficiencies, it cannot erase or fix existing permanent impairments.

The one thing IDF patient data does indicate is that the time to diagnosis for patients with primary immunodeficiencies is not improving. As the following personal stories demonstrate, it is critically important for patients to receive timely and accurate diagnosis. Early diagnosis and proper treatment give patients the best possible opportunity to live healthy, productive lives.
CMS to Remove Preadministration Fee and Reduce Reimbursement for IVIG

The Centers for Medicare and Medicaid Services (CMS) announced new rules that eliminate the preadministrative fee for IVIG infused in the physician’s office and the hospital outpatient department for Medicare beneficiaries. The preadministration fee was introduced by CMS in 2006 to assist physicians in locating and obtaining IVIG. The new rules also further reduce reimbursement in the hospital outpatient department for all Medicare Part B drugs, including IVIG. Both rules will begin in January 2009.

IDF is deeply disappointed with this decision. It is our belief that eliminating the preadministration fee and reducing reimbursement for Medicare beneficiaries in the hospital outpatient department will exacerbate the current access and reimbursement problem.

Citing a 2007 report by the Office of Inspector General, “Intravenous Immune Globulin: Medicare Payment and Availability,” as well as IDFA survey data from 2006, 2007 and 2008, IDF responded to CMS by requesting that the preadministration fee be maintained in both settings, and reimbursement in the hospital outpatient department not be reduced.

Since June, countless patients, physicians and family members participated during the public comment period following the announcement of the proposed rules by using the IDFA Action Alert to send letters directly to CMS and to encourage their legislators to do the same. IDF is extremely grateful for the outpouring of support from the community on this issue, and for the letters sent to CMS by concerned Senators and Representatives.

Please do not become discouraged, but continue your commitment to this issue and join us in the coming year as we carry on our efforts on Capitol Hill. We urge you to alert IDF to any problems you experience obtaining your prescribed product in the setting that is best suited to your needs, and it is especially important to report any Medicare related access issues. We also request that you take a few minutes to complete any IDFA surveys you receive. This data is critical in demonstrating the problems our patients are facing.

As we prepare for the 111th Congress, IDF is reviewing our legislative strategies. We remain hopeful that lawmakers will keep in mind the challenges facing our community and work with us to ensure access to all treatment options, and quality care for all of our patients.

LAW ENSURES HEALTH INSURANCE COVERAGE FOR COLLEGE STUDENTS NATIONWIDE

You spoke and Congress listened! Over the course of five days, more than 700 people used the IDFA Action Alert to rally in support of Michelle’s Law, a bill that provides a 12-month extension for critically ill or injured college students to retain coverage under their parents’ health insurance. This piece of legislation, crucial in protecting the health and well-being of college students with primary immunodeficiency disease, passed through Congress on September 25, 2008. Michelle’s Law was signed into law in the state of New Hampshire by Governor John Lynch on June 22, 2006, and on October 9, 2008, after being signed by President Bush, it became law nationwide.

Michelle’s Law is in honor of New Hampshire student Michelle Morse who was diagnosed with colon cancer her senior year of college. She was forced to remain a full-time student while undergoing chemotherapy to retain her parents’ health insurance coverage. Ultimately, Michelle lost her battle with cancer.

Keeping the struggle of the Morse family and other families throughout the country in mind, IDF would like to thank all of you who used the IDFA Action Alert to contact their Senators and Representatives in support of this legislation, and, of course, Senator Sununu and Congressman Hodes for championing such an important initiative. It is our hope that students in the future will never have to decide between their health and their education.
According to a past Immune Deficiency Foundation survey of patients, the average time from the onset of symptoms to diagnosis is 9.2 years. Some patients, however, are diagnosed rather quickly. For others, finding the source of illness stretches on interminably.

“That nine year average looks pretty good to me,” says John Armes, a 58-year-old CVID patient from Florida. “It took 28 years to diagnose me and all because no one bothered to give me a relevant blood test.”

CVID – or Common Variable Immune Deficiency – is a disorder characterized by low levels of serum immunoglobulins (antibodies) and an increased susceptibility to infections. CVID is a relatively common form of immunodeficiency, and the clinical course varies from patient to patient.

John doesn’t place all the blame on the myriad of doctors he encountered on what, at various intervals, seemed like every two months.

“Look, what you have to remember is that this was so long ago – and I grew up in a small town in Illinois – so going to the doctor back then was something folks didn’t do at the first sign of the sniffles. Besides, he was one of those old country doctors who treated everything with either penicillin or paragoric.”

Armes does’n’t recall his early visits to that ‘old country doctor,’ but he does remember the process that played out over the next 20 years, and took the time to document nearly every experience. John chronicled more than 100 doctor visits, a thousand blood tests, and six major surgeries, including the removal of his tonsils, adenoids, uvula and appendix.

He has suffered from recurring bouts of pneumonia, lung infections, nausea, diarrhea and indigestion. Some medical professionals referred him to psychiatrists, suggesting that perhaps his illnesses were of the psychological variety. He was also diagnosed with chronic fatigue syndrome and sleep apnea – which led to yet another surgery for a deviated septum.

“I’ve learned that you don’t live with CVID,” John tells me, “You fight with it. And you better be ready to fight – fight for everything you need to survive; everything you need to have a good quality of life.”

Matt Roth, a 41-year-old XLA patient from Colorado, also cites respiratory damage as a result of not being diagnosed in a timely manner. Scar tissue on his lungs and chronic bronchitis are the legacy of his elongated diagnosis.

Matt was not quite four when he was diagnosed with X-Linked Agammaglobulinemia. XLA is caused by a defect in the BTK gene that resides on the X chromosome and thus is only expressed in men.

The basic defect in X-Linked Agammaglobulinemia is a failure of B-lymphocyte precursors to mature into B-lymphocytes and ultimately plasma cells.

Matt was too young to remember the recurrent illnesses that had his parents frequently calling upon doctors.

“Constant infections,” is how Matt describes his first three years of life, “and quite a few cases of pneumonia.”

Matt, however, still feels his situation was one of fortune, thanks to a mother who made her living as a biologist and a father who worked in the field of chemistry.

“One of my mother’s brothers was also a doctor,” Matt explains, “My family had quite the support network, and their understanding of the medical field – especially the research side – was of great benefit. It made navigating the healthcare system easier than it is for most people facing a similar situation.”

He is also quick to point out that living with XLA has not prevented him from living a normal life, but he does admit to a bit of naivety about how the public at large – and even the medical community - perceives those with primary immune deficiencies.

“It shocks me that the medical field isn’t better versed in – or even more aware of – primary immune deficiency diseases. I think I’ve long been under the mistaken assumption that immunology study is much more prevalent. It’s such a big part of my life that I assume the rest of the world is just as in tune.”

Ohio resident Mary Rath feels a connection to Matt Roth’s parents; she, too, is a medical professional and credits that career path with helping during the diagnosis of her son’s disease.

“Brian was healthy for the first three months of his life,” Mary relates, “but from that point on, it was doctor visits
and antibiotics. And I’m not exaggerating when I tell you that he took antibiotics about 360 days a year.”

Brian, her son, was diagnosed with Hyper IgM Syndrome, but it was not until after a serious case of pneumonia that almost cost him his life.

Patients with the Hyper IgM Syndrome have an inability to switch their antibody (immunoglobulin) production from IgM to IgG, IgA, and IgE, resulting in decreased levels of IgG and IgA and normal or elevated levels of IgM. The most common form is inherited as an X-chromosome linked trait and affects only boys.

“He was literally at death’s door,” Mary remembers, “and had it not been for a hematologist who kept insisting that normally healthy people do not get pneumocystis, I hate to think of the outcome.”

Pneumocystis is an infection caused by a microscopic fungus that lives in the lungs of people and usually causes no symptoms in healthy people, but can cause pneumonia in infants who have conditions that affect the immune system. Once the fungus in the lung was found, diagnosis came quickly.

Mary documented each time her son got sick.

“Brian had so many illnesses,” she confides, “that I started keeping track of what he had and when. I kept a journal, mainly because each time we’d go see yet another doctor they would ask me for his medical history. After repeatedly laying out this enormous list, I thought it might be easier if I had it all written down.”

Fungal and bacterial are two terms quite familiar to Massachusetts resident Barbara Meade, the difference being the results were visible and not hidden within.

Barbara’s son, Joe, was diagnosed with CGD when he was two. Chronic Granulomatous Disease (CGD) is a genetically determined disease characterized by an inability of the body’s phagocytic cells to make hydrogen peroxide and other oxidants needed to kill certain microorganisms. As a result, patients with CGD have an increased susceptibility to infections caused by certain bacteria and fungi.

“As an infant, Joe suffered from one skin infection after another,” Barbara shares. “He would develop various rashes and boils and at the same time, he was running almost constant fevers that the doctors couldn’t explain.”

“He had developed large lymph nodes on his neck,” Barbara clarifies, “and the doctors had the symptom needed to make the diagnosis.”

“Even though it took two years to diagnose Joe,” she continues, “I – luckily – don’t believe it resulted in additional adverse effects. You usually hear about CGD being diagnosed much later in life – I think that’s when the irreparable damage is more prevalent.”

Sadly, some diagnoses of the quick, accurate variety happen as a result of the death of a preceding sibling. Yvette Shorten lost two boys before her third son, Jerry, was tested at birth for what doctors had determined was responsible for their passing.

Jerry was diagnosed with Severe Combined Immune Deficiency (SCID), the most serious form of primary immunodeficiency disease. SCID, embedded on the public consciousness through the case of David Vetter (“the boy in the bubble”), is a primary immunodeficiency in which there is combined absence of T-lymphocyte and B-lymphocyte function.

Yvette’s first son, who died in 1972, occupied a hospital room across the hall from David.

“They knew right away with my first son, and instantly put him in a germ-free environment. But he was only with us for seven months.”

Yvette is even more forthcoming with the circumstances surrounding the death of her second child.

“A lot of it was denial,” she says without hesitation. “Number one, I was convinced that there was no way I would lose another baby, and to distance myself from that loss, I didn’t go back to the doctor who cared for my first child. Number two, at every single milestone check-up for newborns, my new doctor told me that my second child was perfectly healthy.”

Jerry’s story is nothing short of remarkable. At birth, he was placed in a germ-free environment; at three-and-a-half, he had his bone marrow transplant.

(Continued on next page)
Now 22, he works as a corrections officer in Texas. And not hidden away in an administrative office, either, he walks the front lines of the general population. 

"Oooh... I wasn’t exactly pleased to hear that news," Yvette laughs. “And I told him about it, too! Jerry waited for me to finish my lecture and then made a point to use my own words against me.”

But she couldn’t argue with his response. Throughout his life, Yvette would constantly tell Jerry that he was special, and that he was indeed part of a greater plan.

“He reminded me that I’ve always preached about the power of prayer and faith,” Yvette continues, “and told me he was just living his life the way I had taught him – the way God had planned.”

Beyond their connection to immune deficiency, these five extraordinary people share a couple of other common threads.

All would like to see medical schools worldwide expand their curriculum and offer more than a cursory glance at the immune system.

And all agree that arming yourself with volumes of knowledge about the disease - even though that puts additional pressure on the patient and their family – is the first step toward feeling like you’re not in this alone.

New Web Site
www.donatingplasma.org

Plasma donors looking for information about eligibility, how plasma is used and locations of source plasma collection centers now have a new, one-stop resource to guide them. On September 17, 2008, the Plasma Protein Therapeutics Association (PPTA) launched www.DonatingPlasma.org, a Web site dedicated to raising awareness and providing information about source plasma donation and how it is used to produce therapies that save and improve lives. Debunking myths associated with plasma donation and providing testimonials on the importance of plasma from patients, donors and physicians will allow individuals, the media, local policymakers and the general public to become better informed about how plasma is integral to a global medical chain.

“There are often many misconceptions about plasma and how it is donated,” said Marcia Boyle, President & Founder of IDF. “This site will help take the mystery out of the process and hopefully increase the number of donors, which is always good for our primary immunodeficiency community.”

Visitors can use a zip code search to find a plasma collection center near them in the U.S., or search a country list for centers in Europe. An FAQs section will answer the most commonly asked questions about plasma donation and the differences between blood donations for transfusion medicine in local hospitals and plasma donations used to produce therapies for rare, chronic diseases and disorders like primary immunodeficiency diseases, hemophilia and alpha-1 antitrypsin deficiency.

Macey Holleman, daughter of IDF volunteer Ursula Holleman, visited the Biomat plasma center in Macon, Georgia. Melvin Young, Manager, gave her a complete tour of the facility and explained every step of the plasma donation process. Macey was able to speak to several donors and explain how their plasma donation helped her. Several donors commented that they were glad to know how much their time and donation helped her. Thanks Macey—we are proud to have you represent IDF!
This summer, 200 adults and 80 youth from 21 states came from throughout the country to join IDF to put the Spotlight on Primary Immunodeficiency at the IDF Family Retreats. The Gold Canyon Golf Resort in Gold Canyon, Arizona in June and the Hueston Woods Resort and Conference Center in College Corner, Ohio in September provided beautiful backdrops for patients, family members, healthcare professionals and members of industry to share knowledge, experiences and many laughs.

The Family Retreat weekends featured presentations for adults on a wide range of topics affecting patients with primary immunodeficiency diseases, as well as a fun-filled schedule of activities for youth attendees throughout the day. Saturday night provided an opportunity for everyone to relax and put their feet up to enjoy the beautiful settings with a barbecue followed by a family friendly outdoor movie and snacks.

IDF would like to extend special recognition to Gail Moore and her dedicated team of helpers who make these family retreats successful year after year, since 1997. The 2008 IDF Family Retreats were sponsored, in part, through educational grants from the American Academy of Allergy, Asthma, & Immunology, Baxter Healthcare Corporation, CSL Behring, Grifols, IgG America/ASD Healthcare, Octapharma and Talecris Biotherapeutics.

“‘I love the family retreats. My 13 year old is very happy while I am in classes. If she was unhappy I would be unhappy.”
“Thank you for having our family to this retreat. I feel I have started on a new journey.”

“My son now understands his condition. Thank you for educating him.”
“I had the most wonderful time. Everyone, and I mean everyone, has gone above and beyond.”
“Beautiful setting, great family atmosphere!”

A Special Thanks to our Presenters!
Melvin Berger MD, PhD
Cori Daines, MD
Michael Daines, MD
Maggi Dodds, CPNP
Kim Duff, RN, BSN
George Gwinn, MD
Leslie Harman, MA, MFT
Terry Harville, MD, PhD
David Hauswirth, MD
Robert Hostoffer, Jr., DO
Kim Jones
Judi Miller
Jennifer Puck, MD
Richard Schiff, MD
Jennifer Seda, MD
John Seymour, PhD, LMFT
Lynne Szott, RN
Plasma Centers Throughout the U.S.
Octapharma Agrees to Acquire 33 Plasma Centers from International BioResources

Octapharma announced that it will acquire 33 plasma collection centers from International BioResources (IBR), the largest independent source plasma collection company in the United States. IBR will develop and staff the plasma centers with over 800 employees. The plasma centers will be located predominantly in the East and Midwest.

Plasma is the source of numerous proteins used for drug development and therapeutic purposes. Octapharma’s core business is the development, production and sale of high quality, virus safe plasma derivatives, including IVIG. In the U.S., Octapharma’s IVIG product, octagam®, is used to treat disorders of the immune system, and Octapharma’s Albumin (Human) 5% is indicated for the restoration and maintenance of circulating blood volume.


Talecris Enters into Definitive Merger Agreement with CSL

Talecris Biotherapeutics, Inc. announced that it has signed a definitive merger agreement with CSL under which CSL has agreed to acquire Talecris for $3.1 billion in cash. This amount includes net debt, which as of June 30, 2008 was approximately $1.2 billion, implying an equity value as of that date of about $1.9 billion.

The combination of Talecris and CSL will result in:
- a combined company with one of the broadest portfolios in the plasma-derived therapeutics industry with key products in each plasma therapeutic area;
- one of the most robust and efficient plasma collection capabilities in the industry, to better assure supply of plasma for manufacturing essential therapies;
- expanded and integrated manufacturing with greater efficiency and improved ability to supply therapies;
- an enhanced R&D pipeline;
- operating efficiencies that will facilitate further investment in R&D, quality, compliance and plasma collection; and
- improved and more reliable supply of therapies to patients and customers through efficiencies, avoidance of capacity constraints and more assured plasma supply.

Closing of the transaction is subject to receipt of certain regulatory approvals, as well as other customary conditions. If the necessary approvals are not obtained within one year, either CSL or Talecris will have the right to terminate the transaction.


Talecris Biotherapeutics Helps Patients Receive Gamunex During Lapses in Private Insurance Coverage

People with PI require IGIV on a regular basis and without regular treatments, which can be disrupted in the often complex and challenging health insurance environment, PI patients can suffer from serious infections and illnesses. For this reason, Talecris developed the Gamunex Connexions Certificate Program, to help ensure that patients can temporarily continue to receive their therapy during times of uncertainty.

To qualify for the Gamunex Connexions Certificate Program, a patient must have third-party, private health insurance as their primary health insurance and be using Gamunex regularly for PI or ITP. Full details about the program are available by calling 1-888-263-8243.


Grifols Breaks Ground on New IVIG Facility

Grifols announced that its new facility is anticipated to be operational in 2013 and represents an expansion of Grifols’ existing manufacturing capabilities in Los Angeles. Grifols’ new production facility will almost double the company’s IVIG production capacity and will utilize the same proprietary technologies and process flow designs employed at the company’s existing IVIG production facility in Barcelona, Spain.

Building this additional production capacity represents one more step in Grifols’ multi-year global growth plan to meet increasing patient need for lifesaving plasma therapies. Other elements of the long-range investment plan include expanding plasma collection capacity and additional production and testing facilities.

Excerpted from Grifols News Release, October 6, 2008.

Data Published in Journal of Clinical Immunology Show Privigen™ Demonstrates Effectiveness and Tolerability in Patients with Primary Immunodeficiencies

New L-Proline Stabilized Immune Globulin Intravenous (Human) 10 Percent Liquid can be stored at room temperature, offering convenience to healthcare professionals.

Data published online in the current edition of Journal of Clinical Immunology demonstrates that Privigen™, the new liquid immune globulin intravenous (human) 10 percent product from CSL Behring, is effective and well-tolerated in patients with Primary Immune Deficiencies (PI).


Grifols Launches PediGri® On Line for its US Plasma Therapies

Grifols launched in the US, its proprietary PediGri® On Line system that gives healthcare providers access to quality and safety information about the plasma used in the production of Grifols’ therapies.

Through a web portal at www.pedigronline.net, registered healthcare providers (including physicians, nurses and pharmacists) can access lot specific information about the individual plasma sources that contributed to each product vial. The Grifols PediGri® system provides full traceability from donation to final product.

Grifols’ PediGri® has been available in Europe for nearly a decade and will now be made available for all Grifols’ plasma therapies marketed and sold in the US.

This past July, the SCID (Severe Combined Immune Deficiency) Community hosted an international conference for families who are affected or have been affected by SCID. The conference was held in the beautiful Blue Ridge Mountains of Virginia, at Wintergreen Resort and Spa. This is the first such event where families with ALL forms of SCID were invited to attend. I am happy to say we had over 140 people in attendance, with families coming from as far away as California and New Zealand! The event provided a wonderful opportunity for patients, families, children, physicians and industry to come together and learn more about this devastating disease, and the quality of life issues that go along with successful treatment. The adult educational sessions offered new, up-to-date information from top experts in the field. The children’s programs were packed with fun-filled activities for all ages, which emphasized teamwork, cooperation, and acceptance. The weekend was an incredibly special time, providing hope, support, and, invaluable information to all who attended.

Many thanks to our excellent presenters who not only came prepared to share the most current information, but also stayed for the weekend and made themselves available to families for extended conversations. Our thanks to: Barb Ballard, Dr. Mei Baker, Dr. Rebecca Buckley, Dr. Fabio Candotti, Dr. Morton Cowan, Joie Davis, Cheryl Deep, Carol Ann Demaret, Dr. Joanna Fanos, Dr. Alan Flake, Dr. Terry Harville, Dr. Harry Malech, Lindsay Middleton, and most importantly, Dr. Jennifer Puck.

A special thanks to IDF for their generous contribution toward this event. Without the help of our wonderful sponsors, this important educational event could not have been possible. We thank you and look forward to collaborating again for future conferences.

Please check out the IDF SCID Initiative section of the IDF website for future conference information.

Many thanks...

The Petrelli and Walsh families “put a face on primary immunodeficiency disease” and thanked the donors and staff for their role in providing lifesaving plasma to our patient community at BioLife Plasma Services in DeKalb, Illinois.
Susan Branch hosted “A Little Texas in Rhode Island” barbecue to benefit IDF on August 29, 2008. The successful event included a silent auction, raffle, and live music, and raised nearly $5,000. Susan, shown on the right, was assisted by IDF volunteer Betty Gordon. Thanks to Susan, Betty, and all of the other wonderful volunteers for their outstanding efforts!

These young ladies participated in the IDF Kid’s Club at the IDF Family Conference Day in St. Paul, Minnesota in July.

Allissa Rastad staffed the information table at a blood drive in honor of her brother Alec. Her mother, Towma Rastad, an IDF volunteer in Massachusetts, worked with the Red Cross to coordinate the event that did double duty as a fundraiser and helped spread awareness about primary immunodeficiency diseases and IDF.

In September, the IDF Family Conference Day in Shrewsbury, Massachusetts provided wonderful opportunities for youth to connect through games and activities in the IDF Kid’s Club and the Teen Track Program.
Small Gifts Add Up

That’s why IDF has created a new “Monthly Giving” Program. At your request, IDF can automatically charge your credit card each month. Imagine what a difference you can make to IDF by giving monthly. For example, if you contribute $25 each month, at the end of the year your total contribution to IDF will be $300! You can receive points or miles on your credit card, and you don’t have to remember to send a check. Gifts to IDF are tax-deductible, and IDF will be very grateful!

All you need to do is fill out this form and send it to IDF!

YOUR GIFT

Yes, I would like to give $__________________________ to IDF every month in 2009.

Please begin charging my credit card (Visa / MasterCard) on (month)__________________________, 2009.

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Marsha Ralich
Carla Richards
Addison Trillo

These donations help IDF to improve the diagnosis and treatment of patients with primary immunodeficiency diseases through advocacy, education and research. If you would like to make a donation, please go on our Web site, www.primaryimmune.org and click the “please donate today” picture in the top right corner. You can also contact us in any of the following ways:

Phone: 800.296.4433 or 410.321.6647
E-mail: idf@primaryimmune.org
Mail: IDF, 40 W. Chesapeake Avenue, Suite 308, Towson, MD 21204
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